Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection against the *National Standards for Safer Better Healthcare*.

Name of healthcare service provider:	Sligo University Hospital
Address of healthcare service:	The Mall Rathquarter Sligo Eircode: F91 H684
Type of inspection:	Announced
Date(s) of inspection:	08 and 09 October 2024
Healthcare Service ID:	OSV-0001089
Fieldwork ID:	NS_0098

About the healthcare service

Model of hospital and profile

Sligo University Hospital is a model 3* public acute hospital. At the time of the inspection, the HSE structures in the region were transitioning to the West North West (WNW) health region† in line with the new HSE Regional Health Areas. The hospital's catchment area included Sligo, Leitrim, South Donegal and West Cavan. Sligo University Hospital also has governance for 35 short-stay beds in Our Lady's Hospital Manorhamilton.

Services provided by the hospital included:

- acute medical and surgical in-patient services
- elective surgery
- emergency care
- high-dependency and intensive care
- diagnostic services
- outpatient and day-care services
- Specialty services included:
    - maternity and neonatal care
    - paediatric services
    - regional services in ophthalmology, neurology, dermatology, rheumatology and ear, nose and throat (ENT).

The following information outlines some additional data on the hospital.

Number of beds under the governance of SUH	**On the SUH site:** 307 inpatient beds 62 day-case beds plus on **Our Lady's Hospital, Manorhamilton site:** 35 inpatient beds plus • 6 dedicated rheumatology inpatient beds and • 10 dedicated rheumatology day-case beds

* A Model 3 hospital is a hospital that admits undifferentiated acute medical patients and provides 24/7 acute surgery, acute medicine, and critical care.

† HSE West Northwest Hospital group comprised six hospitals. These are University Hospital Galway and Merlin Park University Hospital, Sligo University Hospital, Letterkenny University Hospital, Mayo University Hospital, Portiuncula University Hospital and Roscommon University Hospital. The Hospital Group's Academic Partner is the University of Galway.

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publicly available information since last inspection.

During the inspection, inspectors:

- spoke with people who used the healthcare service to ascertain their experiences of receiving care and treatment
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the hospital
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors during the inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection and information received after the inspection.

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with the national standards monitored during this inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality

[‡]Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare.

and safe service is being sustainably provided in the hospital. It outlines whether there is appropriate oversight and assurance arrangements in place and how people who work in the service are managed and supported to ensure high-quality and safe delivery of care.

2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centred and safe. It also includes information about the environment where people receive care.

A full list of the national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1 of this report.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
08 October 2024 09 October 2024	09.00 – 18.00hrs 09.00 – 17.00hrs	Patricia Hughes	Lead
		Robert McConkey	Support
		Eilish Browne	Support - Day 1 of inspection

Information about this inspection

An announced inspection of Sligo University Hospital was conducted on 08 and 09 October 2024 as part of HIQA's statutory role to monitor the quality and safety of healthcare services. HIQA previously conducted unannounced inspections at the hospital in September 2022 and July 2023 respectively. An assessment of compliance with eleven standards from the *National Standards for Safer Better Healthcare* in 2023 found that that Sligo University Hospital was non-compliant in two standards and partially compliant in five standards. The hospital provided a compliance plan which set out actions and timeframes proposed by the hospital to bring the hospital back into compliance. The plan was included in HIQA's 2023 published report.

The inspection in October 2024 focused on eleven national standards from five of the eight themes[§] of the *National Standards for Safer Better Healthcare*. The inspection focused in particular, on the following four key areas of known harm:

- infection prevention and control

[§] HIQA has presented the National Standards for Safer Better Healthcare in eight themes under the two dimensions of capacity and capability, and quality and safety.

- medication safety
- the deteriorating patient[**] (including sepsis)[††]
- transitions of care.[‡‡]

The inspection team visited three clinical areas:

- Emergency department
- Paediatric ward (Children's ward - general medicine and surgery)
- Medical North (gastroenterology including liver disease, general medicine)

During this inspection, the inspection team spoke with representatives of the hospital's management team, quality and risk, human resources, facilities, and clinical staff and with representatives from

- Infection Prevention and Control
- Drugs and Therapeutics
- The Deteriorating Patient (adult and child)
- Transitions of Care

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people using the healthcare service who spoke with inspectors about their experience of receiving care and treatment in the service.

What people who use the service told inspectors and what inspectors observed

Inspectors met and spoke with patients who were receiving care in the emergency department (ED), medical north ward, and with parents and children on the children's ward. Staff were observed wearing appropriate personal protective equipment, in line

[**] Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.
[††] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[‡‡] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

with current public health guidelines. Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the emergency department and in the inspected ward areas.

The adult waiting area in the emergency department had been reconfigured since the last inspection and was no longer separate from the main reception area. This change was in line with the hospital's compliance plan following their HIQA inspection in 2023. The reconfiguration resulted in improved access for patients to the reception area and staff. The security office was located close to reception area improving safety for patients. Mobile phone charging points were now available in the waiting area. There was an audio-visual separate child-friendly waiting area and children's' ED (as recommended in the national model of care for paediatric healthcare services) situated closer to the main body of the adult ED. Patients complimented the care received in the ED. Inspectors asked if there was anything about the service that could be improved, patients spoke about "the waiting times in ED", "excessive noise" and "lights that were too bright" as areas for improvement.

Medical north was a 30-bedded medical ward. Patients complimented the care and attention received, the standards of cleanliness and the range of food choices and food quality available. They made the following comments: "they regularly check to see I am ok even though they are busy", "staff take the time to get to know you" and "the room is comfortable, good space for my belongings". Inspectors asked if there was anything about the service that could be improved. All of the patients spoken with responded that they were happy with their care, service and facilities.

The children's ward had capacity for 18 children with the potential to accommodate an additional four children if required. Parents complimented the care received, as well as the standards of cleanliness and food quality. A child complimented the cleaning staff for their friendliness.

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standards related to workforce and the use of resources. Based on the findings of this inspection, inspectors found that the hospital was compliant with national standard 5.8, substantially compliant with national standard 5.2 and partially compliant with national standards 5.5 and 6.1.

Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.

The hospital had arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services. Organisational charts setting out the direct reporting arrangements for hospital management and the governance and oversight committees remained largely unchanged internally since the last inspection. Externally, the establishment of the six new integrated healthcare regions of which Sligo University Hospital was a member of the HSE West North West (WNW) region, was a new development since the last HIQA inspection. As per previous inspections, the hospital was governed and managed by the hospital manager who now reported to the newly established role of integrated health area manager for HSE WNW-Sligo Leitrim who in turn reported to the new regional executive officer (REO) for the region.

Executive Management Team (EMT)

The Executive Management Team (EMT) was accountable for leading and overseeing all aspects of performance of the hospital and ensuring the delivery of high quality, safe care of patients using hospital services. Chaired by the hospital manager, the EMT met fortnightly. Membership comprised the hospital manager, director of nursing, director of midwifery, the six associate clinical directors (who each reported to their respective regional clinical director, for example, of the managed clinical academic network and they in turn reported to the HSE WNW group clinical director), head of finance, head of human resources and a health and social care professional (HSCP) representative. The EMT had a set agenda which included reports from each directorate. Inspectors viewed minutes of the EMT and noted that it was meeting in line with its terms of reference (TOR), the minutes followed a structured format and were action orientated. Items such as 'a patient story', finance, HR, updates on the service, capital development, quality and safety, and updates from members of the EMT from their respective areas were included. Progress in implementing actions was monitored from meeting to meeting although these were not always time-bound. The EMT had committees in place for oversight of the four areas of known harm as outlined below and the EMT reported to the HSE WNW Performance and Accountability meeting. The EMT via the hospital group submitted data for inclusion in the monthly HSE Maternity Patient Safety Statements (MPSS) and Hospital Patient Safety Indicator reports which are published on the HSE website although inspectors found that these were incomplete in some areas. This is discussed under National Standard 3.3.

HSE WNW's Performance and Accountability Meeting

The EMT reported to the HSE WNW's performance and accountability meeting at alternative monthly performance meetings. The terms of reference stated that the aim of the meetings was to support performance accountability across general management and

clinical management, with a focus on day to day operational as well as on strategic objectives. Inspectors viewed minutes of those meetings and noted that they followed a structured format, were action orientated and progress in implementing actions was monitored from meeting to meeting. Meetings were chaired by the REO of HSE WNW and were well attended by the EMT including the associate clinical directors from Sligo University Hospital.

Infection Prevention Control

The terms of reference for the Infection Prevention and Control Committee (IPCC), dated November 2022 were scheduled for review in November 2024. The committee was responsible for the development and review of the service to prevent and control healthcare associated infections. It was scheduled to meet at least four times per year and more often if required, for example, in the event of an infection outbreak. It was accountable to and reported to the Quality and Safety Executive Committee (QSEC) and the hospital manager. The meetings were chaired by the assistant general manager. Membership was multidisciplinary. The committee incorporated and acted as an environmental monitoring committee to advise the acute hospital and or local health managers on Legionella control and to develop procedures for their respective healthcare facilities. It liaised with the EMT in relation to strategic developments. The committee worked in tandem with the Hygiene Services Committee. Members of the committee also participated in the wider Hospital Group for the prevention and control of hospital acquired infections. Inspectors viewed minutes from the three most recent meetings held in the year to date and found that they followed a structured format and were action orientated although the responsible person and or timeframe was not always recorded. Items covered included outbreak management, hand hygiene, care bundle updates, incident reports, environmental hygiene, infection prevention updates, antimicrobial resistance updates, capital development projects and funding, HIQA inspections and Health and Safety Authority (HSA) audits. The meetings were well attended by the members.

Medication Safety

Inspectors noted that the terms of reference for the Drugs and Therapeutics Safety Committee (DTSC) remained in draft format although it was stated that they were effective from January 2024. There was no date of approval or signature recorded on them. The aim of the committee was, 'to ensure the safe, rational and cost-effective use of medicines at SUH, and will also oversee relevant activity in Our Lady's Hospital, Manorhamilton (OLHM) and the North West Hospice, Sligo'. The DTSC had a multidisciplinary membership including the chairperson (a medical consultant) and the chief pharmacist (deputy chairperson). It reported to the EMT through the QSEC. It was scheduled to meet every two months. The following sub-committees reported to it: antimicrobial stewardship team, medication safety subcommittee and the Northwest Hospice Drugs and Therapeutics committee. Inspectors were told that the scope of the

committee at Sligo University Hospital included oversight of medication safety and anti-microbial stewardship at the acute hospital, the step-down ward at Our Lady's Hospital, Manorhamilton and the North West hospice in Sligo. The DTSC also provided support to the DON of St. John's rehabilitation unit in Sligo as required. Inspectors viewed the three most recent sets of minutes relating to the committee and noted that attendance and meeting schedules were in line with its terms of reference. They followed a structured format and were action orientated although the responsible person and or timeframe was not always recorded. Inspectors noted that discussions were ongoing in relation to the terms of reference against the background of evolving governance arrangements in the new regional structures.

The Deteriorating Patient

The terms of reference for the SUH Deteriorating Patient Committee (DPC) was dated February 2023. There was a separate terms of reference in use for 'the critically ill and or the deteriorating child - project group'. The DPC reported to the QSEC who in turn reported to the EMT although inspectors found that this was not clear from the terms of reference where it was stated, that 'the DPC are accountable through the relevant line management to the SUH Hospital General Manager and Group CEO via Executive Council'. The frequency of meetings was not stated within its terms of reference. Among its aims was to agree and develop a hospital-wide approach to the care of the deteriorating patient including the standardisation of care, documentation and equipment for the deteriorating patient. The sepsis committee and the simulation committee were sub-groups of the DPC. Membership was multidisciplinary. Inspectors viewed documentation relating to the three most recent DPC meetings held in April, June and September 2024 prior to this inspection. It was chaired by a consultant physician. Attendance at meetings was in line with the terms of reference. The minutes followed a structured format and were action orientated although the responsible person and or timeframe was not always recorded.

Membership of 'the critically ill and or the deteriorating child - project group' was multidisciplinary. The intended frequency of meetings of this group was not stated in the terms of reference. It reported to the QSEC. Among its stated roles and responsibilities was the requirement to 'communicate with the Deteriorating/Unwell Child Saolta Project Group'. Inspectors viewed documentation relating to the three most recent meetings held in December 2023 and in February and April 2024 and found that the meetings were well attended by the multidisciplinary team. Meetings followed a structured format and were action oriented although not all actions were time bound or had a responsible person allocated to them.

Transitions of Care

The hospital had a number of committees in place that dealt with various aspects of transitions of care. These included the unscheduled patient pathway group (UPPG), a navigation hub and an integrated delayed transfer of care committee.

The terms of reference for the UPPG were in date and stated that the role and responsibility of the group was 'to review and improve the flow and experience of emergency patients through Sligo University Hospital and onward into the community. It will agree and co-ordinate the most appropriate model for the implementation of the respective programmes for emergency and or unscheduled patients in line with the national programmes'. The group was accountable to the EMT and was scheduled to meet monthly. It was chaired by the hospital manager and had multidisciplinary membership including clinical leads and the associate clinical director for medicine. Inspectors viewed documentation relating to the three most recent meetings (May, June and July 2024). The group was meeting in line with its terms of reference, however, there was an absence of some personnel who held key roles in transitions of care at all three meetings. The committee's agenda included review of performance metrics, ambulance turnaround times and identification and planning of initiatives to improve patient flow through the hospital and onwards to the community. Minutes indicated that the meetings followed a structured format and were action oriented with a responsible person allocated per task, however these were not always time bound.

A standard operating procedure dated September 2024 outlining the function and procedures to be followed by the navigation hub and roles and responsibilities of the multidisciplinary attendance was viewed by inspectors. It set out that the Hub was to meet five times per week for 15-20 minutes in the morning. It was led by the bed manager or deputy. It was to be attended by all CNMs at designated time slots. Its purpose was to confirm admissions and discharges for the day and to plan for the next day's discharges including escalation in the event of the need to activate the full capacity protocol. Inspectors viewed the published Hospital Patient Safety Indicator Report (HPSIR) reports for the first six months of the year noting that Sligo University Hospital discharged an average of 303 patients per week. There was also up to 30 patients a month, whose transfers to either home - pending a homecare package, stepdown care or rehabilitation, was delayed. Inspectors viewed samples of the bed management reports which included notes on actions being taken to help alleviate pressure on beds.

The integrated delayed transfer of care committee met fortnightly. It reviewed the current number of delayed transfers and updated the action log. Inspectors viewed the three most recent fortnightly anonymised Delayed Transfer of Care Action logs which were action-oriented, had responsible persons assigned to tasks and where progression of work was noted from meeting to meeting. Inspectors heard that the frequency of this meeting was recently increased to weekly in response to ongoing bed capacity issues.

Quality and Patient Safety

The terms of reference for the Quality and Safety Executive Committee (QSEC) were in date. They set out the aim of the committee, 'to develop, deliver, champion, implement and evaluate a comprehensive quality and safety programme with associated structures, policies and processes which are the vehicle for improving quality and safety'. Membership was multidisciplinary. It was operationally accountable to the EMT and the chairperson reported to the hospital manager. The EMT, in turn, reported to the hospital Group Quality and Patient Safety Executive Committee and to the serious incident management team (SIMT). The chairperson of the QSEC was nominated by the EMT and at the time of inspection, a consultant ophthalmologist held this role. It was scheduled to meet every four to six weeks. The Infection Prevention and Control Committee, and the Drugs and Therapeutics Committee were among the committees that reported to it. Other committees reporting to the QSEC included the COVID-19 outbreak committee, hygiene services committee, haemovigilance - blood transfusion group, radiation safety, healthcare record committee, health and safety - hospital watch committee, and medical devices and equipment management committee. Inspectors heard on inspection that the Deteriorating Patient Committee also reported into it.

It was unclear from documentation provided where complaints were overseen at local hospital level. This was previously identified in the 2023 HIQA inspection report. Inspectors noted that complaints were reviewed at the HSE WNW's Performance and Accountability meeting and by the Group Serious Incident Management Team.

QSEC meetings followed a structured format and were action oriented although not all actions were time bound or had a responsible person allocated to the task. Minutes of meetings submitted to HIQA showed that the committee had oversight of committee work, the hospital risk register, monthly national incident reports, logs of serious incidents, health and safety, and data protection.

Emergency Department Specialty Management Team (SMT)

Inspectors viewed the terms of reference for this team which were in date. The stated responsibility of the team was 'to have overall responsibility for reviewing performance against agreed targets, identify reasons for underperformance and agree actions required on behalf of the specialty where activity, resources or quality and or safety performance is not in accordance with targets'. The SMT was scheduled to meet every four to six weeks and was chaired by the specialty coordinator (consultant in emergency medicine). It reported to the EMT. Membership was multidisciplinary and included medical, nursing and administrative staff. Metrics and key performance indicators presented at the meetings included:

- numbers of attendances to the ED – compared to previous years
- numbers of admissions from ED
- conversion rates

- patient experience times (PET) for admitted patients, non-admitted patients, patients aged 75 years or more and children
- ambulance turnaround times
- patients who left before completion of treatment.

Inspectors viewed documentation relating to the three most recent meetings held by the SMT in May, July and September 2024. A standard agenda was followed. SMT meetings were well attended and followed a structured format. Parts of the minutes were action oriented although not all actions were time bound. Incident and complaints relating to ED were monitored and discussed. Data in relation to increased numbers attending the ED and a decrease in performance in meeting the PETs was documented. Some improvement was recorded in the September 2024 minutes in respect of PETs over the previous three months, however, this applied only to the non-admitted patients. Inspectors noted that there was also a subgroup in place at the hospital looking at PETs which included the hospital group manager for unscheduled care.

Serious Incident Management Team (SIMT)

This team was established at Hospital Group level. The purpose of the group was to provide leadership, governance and assurance to the hospital group on the management and review of serious incidents and monitor the frequency of themes in complaints and patterns of recurring incidents. Each of the managed clinical academic networks (MCANs) and directorates, had their own SIMTs which then reported to this Group SIMT. Services outside of the MCANs and directorates escalated their incidents via the local hospital quality and patient safety mechanisms. The SIMT was scheduled to meet at least monthly via an online platform and was chaired by the Group clinical lead for quality and patient safety. Membership was multidisciplinary and included group clinical directors, hospital managers, DONs, DOMs and quality and patient safety coordinators from each of the six hospitals. The SIMT reported to the Hospital Group Quality and Safety Executive Committee which reported to the Executive Council of the Hospital Group. Inspectors viewed the redacted SIMT action logs for the June, July and August 2024 meetings and found that they contained attendance logs at meetings held and an update by directorate on incidents under review. There was good attendance by the multidisciplinary team from Sligo University Hospital.

In summary, inspectors found that there were integrated corporate and clinical governance arrangements in place which were appropriate for the size, scope and complexity of the service provided. Inspectors noted some opportunities for improvements in documentation relating to terms of reference and recording of minutes, including actions on reducing performance as outlined above. It remained unclear where oversight of all complaints took place at local hospital level. There is no change in the judgment of compliance from 2023.

Judgment: Substantially compliant

Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.

Inspectors found that the hospital had defined lines of responsibility and accountability for the governance and management of unscheduled and scheduled care in the hospital. As noted in previous inspections, the hospital had a clinical directorate model, each of which had an associate clinical director (ACD) to provide oversight of its work. The directorates included: medical, peri-operative, laboratory, women's and children's, radiology and cancer. The ACDs reported to the hospital manager on an operational basis and on a professional basis to the regional clinical director of their directorates or managed clinical academic network (MCAN)s who in turn reported to the overall clinical director for the HSE WNW region. The director of nursing (DON) was responsible for the organisation and management of nursing services at the hospital. The DON reported to the hospital manager locally and to the chief director of nursing and midwifery (DONM) of the HSE WNW region. The director of midwifery (DON) was responsible for the organisation and management of midwifery and nursing services within the maternity and neonatal services and reported to the hospital manager locally and to the Group DOM of the HSE WNW region.

This standard was assessed as partially compliant in the 2023 HIQA inspection. Inspectors followed up on the 2023 compliance plan and noted that of the 10 planned actions to address partial compliance in this standard, four had been completed and six were either in progress or were yet to commence. Among those yet to be completed, was the inability to progress the filling of staff vacancies in the frailty intervention team (FIT) in the ED, particularly in speech and language therapy and pharmacy. Inspectors were told that although recruitment had resulted in an offer of a post for a phlebotomy nurse in the ED, the offer was not taken up and the post was then 'lost in the pay and number strategy process'. The hospital manager explained that this was due to limits by the HSE on hiring of staff although more recently, recruitment overall was increasing again. Work however, was progressing on the development of an acute medical off-site ward for SUH at St. John's Community Hospital which was due to open at the end of 2024. This would provide 26 additional beds and would come under the governance of Sligo University Hospital. Inspectors were told that posts had been approved and recruitment of staff was underway for this new ward.

A new medical block providing 42 additional beds on-site was also being planned to meet capacity needs. This was at the 'contract to be awarded' stage at the time of inspection and was expected to conclude by end of November 2024. Staff told inspectors that it

would take a further 24 months to complete. It was designed to accommodate an oncology day unit and a cardiac computed tocography (CT) service.

Emergency care at the hospital was led by the clinical lead for emergency medicine under the governance and leadership of the medical directorate which was led by the associate clinical director who in turn reported to the medical clinical director of the hospital group. Access to emergency care for undifferentiated emergency and urgent presentations by both adult and paediatric patients was via the ED on a 24/7/365 basis. The hospital employed seven whole time consultants in emergency medicine, two of which were employed on a temporary or locum basis enabling provision of 24-hour consultant cover. Staff told inspectors that there was a consultant on duty in the ED from 8am to 8pm, five days a week and from 8am to 1 pm on Saturdays and Sundays, and that out-of-hours, the on-call consultant was easily accessible. Inspectors found that the paediatric ED was staffed on a 24/7/365 basis by nursing staff which included paediatric trained nurses and general nurses with paediatric experience. This was an improvement on the last inspection findings. Attendees to the ED presented by ambulance, were referred directly by a general practitioner (GP) or self-referred. There were management arrangements in place to manage patient flow through the hospital, from the emergency department to the community. Hospital activity and performance was reviewed at daily patient flow meetings and actions were taken to support patient flow. The hospital had policies and procedures in place including an admission, transfer and discharge policy, a full capacity protocol and escalation plan as well as policies and procedures relating to the four areas of known harm. These were available to staff via a document management system and accessible on desktop computers.

The hospital was in escalation during the inspection with a full emergency department, seven admitted patients on trolleys in the ED, seven more on trolleys dispersed across the wards and 12 more boarding in the acute assessment unit at 9am on the first day of the inspection. One ward was closed to admissions due to an infection outbreak however staff told inspectors that the outbreak committee would most likely be declaring the outbreak closed later that week. Staff reported that there were outbreaks of infection in the hospital throughout the year to date. Several patients were also being cohorted in three wards due to being known close contacts. Inspectors saw that an area close to the ED which had been developed in recent years to allow for an expansion of the ED but which had not yet been formally opened due to lack of approval for staffing, had been used intermittently to cope with pressure on beds. On the days of inspection, it was being used to provide space for discharge lounge and ease pressure on bed demand. Inspectors were told that safety huddles were conducted four times a day at 8am, 12 midday, 8pm and at 11pm. These were attended by the operational ADON, ADON patient flow, patient flow coordinator/bed manager, CNM3 ED, shift leader in ED, and the consultant in emergency medicine. Inspectors viewed the record from the 8am safety huddle on day one. The record showed a review of the volume and complexity of patients in the ED, staffing levels, equipment notices, challenges such as language barriers and any other items of

situational awareness. It was attended by the consultant-on-call, nursing and administrative staff.

Inspectors visited the ED on the first day of the inspection. The HSE TrolleyGAR[§§] had reported 16 admitted patients awaiting a bed at 8am. Five of those were in the ED while the remainder were in the acute assessment unit (AAU). Seven of the 16 patients had been waiting for a bed for 24 hours or more. None of the seven were aged 75 years or more. Inspectors reviewed the patient experience times as they were at 11am. All of the patient experience times breached the HSE target times as follows:

- Out of a total of 39 patients registered and present in the ED at 11 am on day one of this announced inspection, twenty patients (51%) were waiting more than six hours in the ED after registration (HSE target: 70% should be admitted or discharged within six hours of registration)
- Sixteen patients (41%) were waiting more than nine hours in the ED after registration (HSE target: 85% should be admitted or discharged within nine hours of registration)
- Five patients (12%) aged 75 years or more were waiting more than six hours in the ED after registration (HSE target: 95% of this age cohort should be admitted or discharged within six hours of registration)
- Five patients (12%) aged 75 years or more were waiting more than nine hours in the ED after registration (HSE target: 99% of this age cohort should be admitted or discharged within nine hours of registration)
- Two patients (5%) both aged 75 years or more were waiting more than 24 hours in the ED after registration (HSE target: 99% should be admitted or discharged within 24 hours of registration).

Inspectors sought information on the following interval times for day one and day two of the inspection and found that these too were prolonged, although there was a noticeable improvement by the second day of the inspection:

- Time from registration to triage: range on day one was 07-97* minutes, the mean time was 29 minutes (range on day two was 03-19 minutes, the mean time was 11 minutes)
- Time from triage to medical assessment: range on day one was 25-748 minutes, the mean time was 289 minutes (range on day two was 4-233 minutes, the mean time was 61 minutes)

[§§] TrolleyGAR: this is a system run by the HSE which enables daily monitoring of ED performance and helps trigger the hospitals' response during busy periods.

- Time from medical assessment to time of decision to admit: range on day one was 123-700 minutes, the mean time was 476 minutes (range on day two was 101-791 minutes, the mean time was 338 minutes)
- Time from decision to admit to time admitted to a bed on a ward: the mean time on day one was 353 minutes, range was not provided (range on day two was 76-212 minutes, the mean time was 144 minutes).

*Inspectors enquired into the circumstances of patients waiting up to 97 minutes from registration to triage and accepted the explanation for this in this instance which related to one person.

The HSE TrolleyGAR had reported 24 admitted patients awaiting a bed at 8am on the second day of the inspection. Ten of those were in the ED while the remainder were in the acute assessment unit (AAU) and in ward corridors. Seven of those patients had been waiting for a bed for 24 hours or more.

Inspectors were told that 170 patients presented to the ED on the 07 October 2024 and 132 patients attended on 08 October 2024. The conversion rate (the percentage of patients admitted from the total number of patients who presented to the ED) on the days of the inspection was 34% (the running average for the year to date was 25.82% which was an increase on the previous two years). The average length of stay for a medical patient was 7.6 days and for a surgical patient was 5.2 days which met with HSE targets. On day one of the inspection, there were 28 patients in hospital beds who had been medically discharged but were waiting on provision of home care packages or on beds in community hospitals or long-term residential care. The published results on the HSE Hospital Patient Safety Indicator report (HPSIR) showed an average of 30 delayed transfers of care for the first six months of the year. The report also showed a progressively upward trend in the percentage of patients aged 75 or more who were admitted or discharged within nine hours of registration (from 37% in January to 52.4% by June 2024). Inspectors noted that the most recent compliance with this PET was 46% for July 2024. This was a positive trend.

Inspectors sought insights from staff relating to the high trolley counts and overcrowding at the hospital. Staff provided documentation and spoke about the trends in ED attendances, for example, an increase in ED attendances from 2018-2023, a higher proportion of older people being admitted and, an overall increased average length of stay. ED attendances had increased by a further 9% between 2021 and 2023 with the biggest increases seen in the 0-16 and in the 65-75 age groups. New attendances to the ED consistently accounted for over 90% of all ED attendances. Compliance with the six-hour PET during the 12-month period September 2023 to August 2024 was averaging 43% (HSE target: 70%) while it was 63% for the nine-hour PET (HSE target: 85%) however, an upward trend in compliance was noted over the last 4 months of this period for both PETs.

Inspectors noted that attendances to the ED had increased by a further 5.27% since 2023 averaging up to 3500 per month which equated with an average of 115 attendances per 24 hour cycle. Staff told inspectors that attendances of 3659 patients in May 2024 was a record month for the hospital. Inspectors reflected that this was the third inspection in three years where overcrowding was evident in the ED and patient experience target times were breached. Daily data published on HSE's TrolleyGAR demonstrated consistently high trolley numbers both in the ED and on the ward areas as well as high numbers of delayed transfers of care. This trend was also noted in the SMT minutes as outlined under National Standard 5.2. Inspectors noted that a number of outbreaks of infection had also negatively impacted access to beds throughout the year. Inspectors viewed minutes from a meeting held in September 2024 from the SUH subgroup for patient experience times where it was noted that there was one medical registrar on duty at weekends for the whole hospital. Actions included further audits and discussion with the associate clinical director for medicine. A further meeting of that group was planned for October 2024. The ED had admission avoidance pathways in place for example, deep vein thrombosis (DVT). There was also a respiratory clinical nurse specialist and advanced nurse practitioner on duty and a geriatrician on duty to see patients. Staff told inspectors that access to such specialist staff and pathways of care had led to a reduction in admissions but that the number of overall presentations had continued to increase.

Inspectors visited the Acute Assessment Unit (AAU) on the second day of the inspection. This unit had capacity for 12 patients and was open 24 hours a day, seven days a week. There was a medical registrar and SHO on duty and on-site for the AAU during core hours with cover from a hospital site on-call registrar out-of-hours. GPs could refer directly here or ED staff could refer patients following initial triage. Nine admitted patients had boarded there overnight due to lack of beds on the wards. One patient was in isolation for infection prevention and control reasons. As a result of the level of occupancy, AAU patients were being seen in a day room where vital signs could be carried out and in the discharge lounge where they could be medically reviewed. Staff told inspectors that up to 24 patients used to be seen in the AAU prior to COVID-19 but this had reduced by up to 75% since then due to the lack of capacity at the hospital resulting in admitted patients being frequently boarded in the AAU. The hospital management and patient flow co-ordinator had recently updated the GP community of the inclusion and exclusion criteria for referral to the AAU.

Inspectors sought an update from the hospital manager on the availability of beds in the community and, access to homecare packages against the identified need from Sligo University Hospital. The hospital manager submitted a report received from Community Care in October 2024 after the inspection. It outlined that from a total of 218 beds (stepdown, rehabilitation, long-term residential) across five community hospitals in Community Health Organisation one (CHO1), 60 beds (27%) were closed at the time of inspection due to essential fire and or IPC works. A further two short-term care beds in Leitrim were closed permanently to meet regulations however, 20 additional beds with private nursing homes had been temporarily contracted by CHO1 to help address the

delayed transfers of care from Sligo University Hospital. The report also outlined that provision of home care packages was operating with the HSE target but that an 8.85% increase in demand on home care packages was forecasted and waiting lists were in place.

The rate of patient flow as witnessed by inspectors in the ED during the inspection resulted in overcrowding in the ED with admitted patients being nursed on trolleys in the main corridor under bright lights and with the noise and bustle of a busy ED. Overcrowding and a protracted stay in the ED is a risk to quality and patient safety and has been shown to be associated with increased morbidity and mortality for patients.

Inspectors found that the management arrangements in place to support the delivery of safe, high quality healthcare services in relation to infection prevention and control (IPC), medication safety, the deteriorating patient and transitions of care as described under National Standard 5.2 were all functioning in line with their terms of reference.

Patients with a known multi-drug resistant organism (MDRO) had a flag on their details on the hospital's integrated management system to alert staff of risk of infection and so guide best bed placement in line with hospital policy. Staff in the clinical areas inspected reported 'very good access and support from the IPC team'. Compliance with hand hygiene and screening for infection is discussed under National Standard 3.1.

In relation to medication safety, inspectors viewed the minutes provided for the three consecutive drugs and therapeutics committee meetings held in March, May and June 2024 and noted that apologies were received from key senior nursing and midwifery members in respect of all three meetings.

Inspectors noted that the Deteriorating Patient committee reviewed the audits of the early warning systems and the *Identify, Situation, Background, Action, Recommendation* (ISBAR) tool, used for communicating care handover or seeking a review or advice on a patient. The committee followed up on shortfalls in audit results and on recommendations arising from incidents reviewed by the Serious Incident Management Team.

In relation to transitions of care, inspectors noted that a comprehensive ED post triage and or admission nursing assessment and care plan of adult patients, devised in December 2023, was now in use. The Unscheduled Patient Pathway Group was monitoring compliance with four key performance indicators: no patient aged 75 years or more was to wait in ED for 24 hours or more, the maximum number of delayed transfers of care per day was not to exceed eight, the trolley count per day was not to exceed eight and the length of stay which exceeded 14 days was not to exceed 60 patients and should not exceed 28 days. As found on inspection, not all of these KPIs were met. Hospital staff were using predicted dates of discharge to help focus the monitoring and delivery of care plans, and whiteboards to track the schedule of tests or interventions planned and provided for patients.

In summary, this was the third inspection of Sligo University hospital in three years where despite efforts being made by hospital staff to examine and address the causes and contributing factors leading to ongoing delays in the rate of patient flow through the ED and the time intervals experienced by patients between the various points of care, little progress in reducing the patient experience times was seen on inspection. This area requires significant and ongoing efforts to ensure that patients can access emergency care in a timely manner and can either be discharged or admitted to a hospital bed on a ward.

Judgment: Partially compliant

Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Sligo University Hospital was monitoring and reporting on data to continually improve the quality, safety and reliability of healthcare services.

The hospital had participated in the national point prevalence study of Hospital-Acquired Infections & Antimicrobial Use conducted in 2023 which was published by the Health Protection Surveillance Centre (HSPC) in 2024. That showed Sligo University Hospital overall had performed better than the national average. The prevalence of healthcare associated infection at Sligo University Hospital was 6.5% (national average was 7.4%). The prevalence of antimicrobial use was 36.4% (national average 40.4%). Inspectors noted that these figures were increased from previous point prevalent studies conducted in 2017 and 2012 but national average rates had also increased over this time period.

The rate of new cases of hospital-acquired *Staphylococcus aureus* bloodstream infection was averaging 0.62 per 10,000 bed days based on published Hospital Patient Safety Indicator Report (HPSIR) results for the first seven months of the year. This met the HSE target of less than 0.8 per 10,000 bed days. Inspectors noted that the full year result was 0.85 in 2023 and 0.47 in 2022. Inspectors viewed the quality improvement plan dated September 2024, devised by the infection prevention and control team to focus attention on further reduction of incidence. The rate of new cases of hospital-associated *Clostridium difficile* per 10,000 bed days was averaging 1.54 per 10,000 bed days for the first seven months of the year and was within the HSE target of less than 2 per 10,000 bed days. It had averaged at 1.85 in 2023 and at 2 in 2022. Inspectors viewed the quality improvement plan dated August 2024, devised by the infection prevention and control team to focus attention on further reduction of incidence. The number of new cases of Carbapenemase Producing *Enterobacterales* (CPE) was 22 for the first seven months of the year. This is discussed further under National Standard 3.1.

The hospital submitted audit results of compliance with the WHO Five Moments of Hand Hygiene once a year to the Health Protection and Surveillance Centre which are published. This is discussed further under National Standard 3.1.

The hospital had participated in a national compliance audit of medical and surgical sepsis in May 2023. The audit was led by the Group ADON for sepsis and the deteriorating patient and also involved the resuscitation officer, the cardiac rehabilitation lead and a medical registrar. Recommendations were made in respect of governance, education, sepsis screening, diagnosis and documentation which were monitored by the deteriorating patient committee.

The hospital had also participated in a national compliance audit of paediatric sepsis in December 2023. The audit was led by the Group ADON for sepsis and the deteriorating patient and also involved a senior paediatric nurse and paediatric registrar. A quality improvement plan listing 17 actions was drafted to address any shortfall identified in the audit. Responsible persons and timeframes were identified. This was being monitored by the deteriorating patient committee.

The hospital was monitoring the number and type of Serious Reportable Events as part of its Hospital Patient Safety Metrics which were reviewed at the Quality and Patient Safety Executive Committee meetings. This is discussed further under National Standard 3.1.

In summary, the hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Judgment: Compliant

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.

The human resource (HR) manager for the hospital reported to the hospital manager and also to the 'director of people' at HSE WNW regional level. The hospital staff monitored absence levels, turnover and compliance with mandatory training. These KPIs were reviewed at EMT and reported to the HSE WNW on a monthly basis.

This standard was assessed as partially compliant in the 2023 HIQA inspection. Inspectors followed up on the 2023 compliance plan and noted that of the four actions planned to address partial compliance, three had been completed and one was in progress. This related to the filling of nursing vacancies in the ED. There was an increase in the number of staff nurses in the ED from 22 WTE in 2022 to 46.5 WTE by quarter three in 2024. Inspectors heard that derogations had also been received and four additional clinical nurse manager – grade 1 posts had been filled. Recruitment was underway to backfill remaining

ED nurse vacancies. Inspectors were told that all staff had been trained and refreshed in the care of the sick child in the emergency department and that there was either a Registered Sick Children's Nurse (RSCN) or an identified nurse with children's experience on every shift during the day and extended to late evening to cover peak times.

Inspectors viewed the published HSE workforce data for end of July 2024 and compared it with end of year data for 2023. The hospital employed 2135 whole-time equivalent (WTE) people in July 2024 which was 16 WTE less than what was in post by the end of December 2023. This related mostly to a reduction in staff numbers in the patient and client care group (down 10 WTE), and in particular among health care assistants and household cleaning staff. This was noted by the infection prevention and control committee to be having a negative impact on the quality of service provided. Nursing and midwifery staffing levels showed an overall gain of seven WTE. Pharmacy staff had increased by three WTE although there was changes of less than one WTE increase or decrease in other parts of the health and social care professional (HSCPs) group. Staff told inspectors that the overall vacancy rate at the hospital at the time of inspection, based on an approved allocation was 4% (82.76 whole-time equivalent (WTE) posts). The vacancies were among the health and social care professional group, nursing and midwifery, management, patient and client care and general support. Inspectors noted that the national pay and numbers strategy moratorium, which used the staffing numbers that were in place at the out-turn of the year end in 2023, as a baseline going forward had now been lifted and that the Regional Executive Officer for HSE WNW was accountable for the planning and management of staff numbers within the region.

Inspectors spoke with staff who explained that the areas or groups most impacted by vacant posts at the time of inspection were the health and social care professional group (physiotherapy, pharmacy and laboratory), household staffing and the administration and clerical group. The vacancies had been reviewed by the EMT, placed on the risk register with documented controls and brought to the hospital group. Approval had recently been granted to fill posts. Recruitment was underway and most of the new recruits were to be in place by December 2024. Minutes of the EMT meetings outlined discussion on how to optimise the physiotherapy resource for the frailty intervention team in the ED. Inspectors were told however, that there were particular challenges in recruiting medical laboratory scientist officers due to availability of same.

Of the 104 WTE consultants employed (99 WTE), 18 consultants were employed on a temporary or locum basis. Five consultants including two temporary or locum consultants were not on the specialist register of the Irish Medical Council. It was unclear on inspection whether support and oversight, as is required in line with national guidance, was formally in place for each consultant in this cohort of consultants. There was seven WTE ED consultants in post with an eighth post being filled at the time of inspection. This was a positive finding enabling improved consultant on site cover.

In the last year, the annual turnover rate was reported to be 3.4% excluding medical staff. Absenteeism was noted to be high at 8% with the patient and client care staff group most affected. Inspectors heard that one eighth of the absenteeism related to COVID-19, while recent changes in legislation where 'parents leave' had increased from seven to nine weeks had also contributed to the increased absence rate. Inspectors heard how the HR department were working with staff by providing workshops on the attendance management policy and 'return to work' interviews. Inspectors heard how risks associated with HR are escalated to the hospital risk register which is reviewed by the QSEC and the EMT at monthly meetings. Inspectors heard how the hospital manager and senior staff have engaged at a regional level to plan a succession planning and development programme for staff. The hospital service provider ran a quarterly induction programme for new staff. Staff had access to both an employment assistance programme (EAP) and an occupational health service to which they could self-refer or be referred by their line manager.

There was 24-hour security cover in place at the hospital. In relation to prevention of violence, harassment and aggression, the hospital manager had instituted a Hospital Watch Programme in association with heads of department, the mental health team, security personnel and An Garda Síochána (police). They were meeting every two months. Staff were receiving upskilling in effective communication and de-escalation. This initiative is commended.

The hospital had recently appointed one WTE quality and patient safety manager who was supported by 1.5 WTE quality and patient safety coordinators, one WTE clinical risk support officer, a half time clinical audit facilitator and two WTE clerical officers. The hospital service provider had a full-time designated complaints officer who reported to the quality and patient services manager. The patient advice and liaison service (PALS) officer post was vacant and the approval process to fill the position had commenced at the time of inspection.

During the inspection, inspectors asked about staffing levels in the inspected areas compared to the intended rostered arrangements as follows:

The planned roster on ED during the inspection comprised 14 nurses on duty seven days a week including the shift leader, a CNM2. There was also one CNM2 on duty for the care of admitted patients during the day. There were 12 nurses on night duty including the shift leader. Those staffing numbers included a CNM2 and one paediatric nurse on duty each day and one paediatric nurse on night duty for the paediatric ED. Staff told inspectors that two RGNs were undertaking training to qualify as registered sick children's nurses. Four healthcare assistants were also rostered for the ED 24/7. On the day of inspection, the staff were one nurse and one healthcare assistant down due to leave requirements.

The planned roster on medical north was for six nurses and two to three healthcare assistants on duty per day, seven days per week (minimum of three nurses covered the 12 hour shift) plus one CNM2 on duty daily, core hours – Monday to Friday. There were three

nurses and one healthcare assistant rostered for duty seven nights per week. Staff told inspectors that these levels may be increased through the support of agency staff, if available, for patients identified as needing additional level of care or observation. Inspectors were informed that vacant shifts and or reduced shift cover was escalated through the line manager or the ADON on-site to see if staff could be redeployed to assist. Inspectors viewed the rosters for the previous week and noted that the ward was short of rostered nurses each day apart from one in the previous week. Staff explained to inspectors that during a period of high activity and staff shortages, a risk assessment was conducted earlier in the year and as a result, it was agreed that the ward could not accommodate trolleys until the situation improved.

The planned roster on the Children's ward comprised five nurses on the day shift and four on duty after 5pm Monday to Friday. Four nurses were rostered for day duty at weekends for the full 12 hour shift. Three nurses were rostered to work on night duty seven nights a week. The full complement was on duty at the time of inspection.

Resources specifically allocated to infection prevention and control at the hospital included two WTE consultant microbiologists, one WTE ADON (this post was vacant at the time of inspection), two WTE clinical nurse managers – grade 2 (CNM2) and two clinical nurse specialists (CNS). All of the nursing staff reported to the DON in the absence of the ADON. The hospital also had one WTE antimicrobial surveillance scientist.

Resources specifically allocated to medication safety included one WTE chief pharmacist, one WTE medication safety pharmacist, one WTE antimicrobial pharmacist 22.3 WTE pharmacists and 18.91 WTE pharmacy technicians. This reflected a reduction of four WTE pharmacy positions lost through reduced hours which had not been replaced.

Inspectors found that the hospital overall, was not reaching its KPIs in relation to mandatory training by all staff groups in relation to attendance within the previous 24 months at the following:

- infection prevention and control (both standard based and transmission based precautions, outbreak management, hand hygiene). Attendance ranged from 12.6 to 69% compliance among staff groups, below the HSE target of 90%
- early warning systems
    - Irish National Early Warning System (INEWS). Attendance ranged from 17 to 75% compliance among staff groups
    - Irish Maternity Early Warning System (IMEWS) – no results for nursing staff (100% compliance for midwifery and medical staff)
    - Paediatric Early Warning System (PEWS). Attendance ranged from 82.6 to 100% compliance for medical and nursing staff. 100% of staff in ED had been trained in the use of the national Paediatric Early Warning System (PEWS)
    - Emergency Medicine Early Warning System (EMEWS) 85% compliance by nursing staff in the ED, no results for medical staff in the ED

- basic life support, attendance ranged from 47.2% for medical staff to 92% for nursing staff
- national guidance on clinical handover with ISBAR (Identify, Situation, Background, Action, Recommendation). Attendance ranged from 6 to 68% compliance among staff groups.

Inspectors heard from staff that there were problems with access to training records of staff from HSELanD as it was not aligned to the hospital's staff pay and management system which resulted in managers having to seek reports of training from HR. The medical manpower manager queried the accuracy of records as many NCHDs had yet to upload their mandatory training records. Inspectors noted this was the third inspection in three years where it has been noted that there is a need for the hospital's service provider to ensure that compliance levels with attendance at mandatory training is in line with hospital and national targets. Of note, inspectors viewed records of mandatory training in Medical North ward where attendance at hand hygiene was 100% among nurses and healthcare assistants, at medication safety-95%, INEWS-95%, Basic Life Support-100% and ISBAR-100%. Compliance levels in the remaining areas of mandatory training required improvement at ward level.

Staff told inspectors that services available to staff at the hospital included an employee assistance programme, occupational health service and access to a clinical psychologist. Staff spoke with a representative of the non-consultant hospital doctor group who outlined the content of the induction programme and the support and services available to staff on offer. The culture of the hospital was described as excellent and inspectors heard that it was a good place to work with good opportunities to learn in a supportive environment.

In summary, while the overall staffing situation was being managed and staffing on the inspected areas had improved in medical and nursing in ED, vacancies in physiotherapy, pharmacy and medical social work remained unfilled and this situation was impacting the patient flow through ED and the quality of service throughout the hospital. Significant improvement in attendance, and in the assurance of compliance with attendance at mandatory training, in line with national guidance is required. Hospital management need to ensure that arrangements are in place, to provide support and oversight for all consultant staff who are not on the specialist register, in line with national guidance.

Judgment: Partially compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred.

Inspectors found that the hospital was compliant in National Standards 1.7 and 3.3, substantially compliant in National Standard 1.8 and partially compliant in National Standards 1.6, 2.7 and 2.8 and 3.1.

Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.

People have a right to expect that their dignity, privacy and confidentiality would be respected and promoted when attending hospital[***]. Person-centred care and support promotes and requires kindness, consideration and respect for the dignity, privacy and autonomy of people who require care. It supports equitable access for all people using the healthcare service so that they have access to the right care and support at the right time, based on their assessed needs. When human dignity is upheld in healthcare settings, it supports people using services to feel safe and helps improve their outcomes.

This standard was judged non-compliant for ED and substantially compliant for the wider hospital following the 2023 HIQA inspection. Inspectors followed up on the 2023 compliance plan and noted that of the six actions planned to address partial compliance in this standard, three had been completed and three were in progress. Among the plans from 2023 yet to be implemented was a planned increase in the number of staff available within the ED at night to care for admitted patients. While approval for such posts was not provided, the hospital management said that they were using agency staff to increase the nurse to patient ratio for this particular cohort of patients. Inspectors were told that plans to maximise patient space in the ED by opening the remaining zone were dependent on the approval and recruitment of additional staff required for this area but that this was expected to be in place shortly and finally that an additional 26-bedded ward was expected to be commissioned for use in St John's Hospital, Sligo by end of 2024.

Inspectors however, noted that overcrowding in the ED continued to impact negatively on the privacy and dignity of patients during this inspection. Privacy, dignity and autonomy was promoted and upheld insofar as was possible in an ED environment for patients being cared for in designated bays or cubicles. For example, curtains were secured around patients to provide privacy and protect their dignity when providing personal care. They

[***] Health Information and Quality Authority. *Guidance on a Human Rights-based Approach in Health and Social Care Services*. Dublin: Health Information and Quality Authority. 2019. Available online from: https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services

had access to a call bell and to a locker for their belongings. A chair was provided in the cubicle for a family member to take a seat beside them if required.

Inspectors noted that these facilities however, were not available to admitted patients being cared for on trolleys on a corridor in the ED where there was considerable passing traffic by staff. Such patients did not have access to the facilities one would have in a ward-based bed such as a locker for belongings, table tops for meals and drinks, a call bell, a place to charge a mobile phone and or access to shower facilities. At times, it was noisy associated with normal activity levels of an ED. Discussions with patients were overhead by others in the vicinity. Inspectors were informed that a patient at end-of-life could be accommodated in a single room within the ED. The department had a relative's room for privacy and sharing of bad news. When privacy and dignity are challenged, so too is the autonomy of the patient. There was no room to mobilise if the patient was able, and wanted to sit out by their trolley, due to space constraints. Patients were complimentary of care by staff in the ED. They also spoke about 'the waiting times in ED', 'excessive noise' and 'lights that were too bright' as areas for improvement. The ability to sleep is an important need for all but especially for ill patients. The ED is not designed to board patients for longer than necessary to triage, provide emergency assessment and treatment and then admit to a hospital bed, transfer out to another facility or discharge home.

On a positive note, inspectors observed staff taking care to use portable screens where possible to provide visual privacy when attending to personal care needs, monitoring of vital signs and or for medical reviews or simple examinations. Staff told inspectors that patients are taken to a room if intimate examinations are required. Staff were also noted to introduce themselves to patients and to communicate in a sensitive manner. Inspectors noted that electronic information had been implemented since the last inspection and was now available for patients and visitors via QR Codes and or leaflets covering areas such as, emergency department – information for patients and visitors, Advanced Nurse Practitioner (ANP) - Referred Care, and Patient Advocacy and Liaison Services (PALS) Information leaflet.

Inspectors visited Medical North ward which was accessible using a security fob and found that patient charts were securely located while whiteboards used as, 'see at a glance', for information on patients and located at the nurses station did not fully protect patient confidentiality. This was brought to the attention of the ward manager. While inspectors noted information on display on how to access translation services and information on how to access services for grief and loss, there was no available information on display at ward level for patients regarding how to access advocacy services.

Inspectors enquired and heard from staff that they seek to optimise the physical location of patients on the ward, based on their needs and especially when there were additional patients placed on trolleys in the ward corridors or other areas of the ward, to relieve congestion in the ED. Inspectors observed examples of this and also noted that mobile screens were used when a trolley was placed on the corridor.

Inspectors visited the Children's ward and noted that patient charts were located in a staff accessible area however patient names were visible over the beds. Inspectors saw a poster on access to patient advocacy and information leaflets in different languages.

Although inspectors noted the presence of the HSE *Your Service Your Say* (YSYS) posters and leaflets (a service for raising complaints, concerns or compliments) throughout all of the areas inspected, none of the patients in ED who spoke with inspectors were aware of it, some of the patients in Medical North who spoke with inspectors said they were aware of it while all of the parents of children on the Childrens' ward said they were aware of it. All of patients spoken with, said that they would speak with their nurse or the nurse in charge if they had any concerns. Inspectors noted that the Patient Advocacy and Liaison Service (PALS) officer post was vacant at the time of this inspection. This role had been credited for support provided to patients during the last inspection in 2023.

A lack of dignity and privacy in the ED and long waiting times was validated by patients who spoke with inspectors and was consistent with the hospital's overall findings from the 2024 National Inpatient Experience Survey. In the national survey, conducted across 40 hospitals in May 2024, patients gave a score of 7.9 out of 10 for privacy in the ED (national average was 8.0). In other areas of care, the hospital had improved on its 2022 survey findings. For overall experience, patients had given a score of 8.5 to Sligo University Hospital which the survey report stated as, 'significantly above the national score' of 8.3. This is to be commended while noting that the patient experience in ED continues to require improvement.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the hospital including in the emergency department. However, despite staff efforts to maintain patients' dignity, privacy and autonomy, the continued practice of accommodating inpatients in the ED and the placement of patients on trolleys on the ED corridor and on the ward corridors did not enable this. There was no significant improvement in the environment where patients (for who there was no available bed) were cared for since HIQA's last inspection in 2023. There is room for improvement in making information available on how to access advocacy services and on protecting confidentiality. The PALS post was vacant at the time of this inspection.

Judgment: Partially compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.

Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences in all

three clinical areas inspected. Inspectors observed staff being proactive in offering assistance to patients at mealtime and later in assisting patients to mobilise. This was validated by patients who made the following comments about staff on Medical North, "staff are kind and considerate", "very patient", "they regularly check to see I am ok even though they are busy" and the "staff take the time to get to know you", "doctors take the time to explain everything" and "there is a nice atmosphere in this hospital". Staff reported that an increase in choice of nutrition and availability of snacks at night was introduced following results of a previous national inpatient experience survey. Patients who spoke with inspectors on Medical North complimented the comfort of their rooms and the space for their belongings. Inspectors observed specific signage to assist patients with dementia, to find the bathroom. Patients in the ED and parents of children on the childrens' ward complimented the care received. Parents of children also reported satisfaction with the standards of cleanliness and food quality. A child complimented the cleaning staff for their friendliness. As outlined under National Standard 1.6, ED staff were observed taking care to protect and promote respect for admitted patients in the ED corridor in whatever way they could, in what was a challenging environment. They did this by their use of mobile screens where possible, facilitating patients to access a shower in the Acute Assessment Unit if required and by communicating with patients in a kind and respectful manner.

In summary, staff were observed promoting a culture of kindness, consideration and respect.

Judgment: Compliant

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

This standard was marked partially compliant in the 2023 HIQA inspection. Inspectors followed up on the 2023 compliance plan and noted that of the five actions planned to bring this standard into compliance, two had been complete and three were in progress.

The hospital staff reported commencement of use of an electronic complaints management system in March 2024. This was being used to monitor the number of complaints but staff had yet to commence tracking and trending the data which they said related to the vacancy of the quality and safety manager post. This had now been filled at around the time of this inspection.

None of the patients in ED who spoke with inspectors were aware of the HSE *Your Service, Your Say* (YSYS) complaints mechanism. One person said that they would "go online" if they needed to make a complaint. Some patients on Medical North ward were not aware of the YSYS complaints mechanism but all of them said that they would speak with their nurse or the nurse in charge if they had any concerns. Inspectors asked parents of children on the Children's ward if there was anything about the service that could be improved but were told that there was nothing specific. Inspectors enquired as to how a child or parent would raise a complaint if they needed. Family members said that they knew about the YSYS complaints mechanism and inspectors observed the YSYS leaflets on the bedside lockers. One parent explained that they would go to the reception area and ask to speak with the manager.

Leaflets were observed on display in the hospital regarding the HSE's *Your Service Your Say*. As previously outlined, parents of children in the Children's ward were aware of this service and leaflets were observed on patient lockers. Patients in the other inspected areas who spoke with inspectors were not aware of the service but all said that they would either go to a staff member or go online for information if they needed.

The hospital had commenced use of the HSE complaints management system in March 2024. Monitoring of compliance with the target timelines for complaint resolution was in place and inspectors noted that 69% of complaints had been resolved and closed out within the 30-day timeframe by the time of this inspection. This had increased from 62% in 2023. The HSE key performance indicator for this is 70%. Inspectors heard that some complaints related to an incident and in such cases both the complaints department and the quality and patient safety department worked together to investigate and address the underlying issues.

Inspectors heard examples of how some complaints received were escalated to the hospital group level and how they were managed in line with the HSE's *Your Service, Your Say* policy. Staff outlined examples of two quality improvement plans, one complete and one in the planning stage following complaints.

Staff explained how they had recently completed a self-assessment against the 36 recommendations from the Ombudsman's *Learning to Get Better* report and had found that they were compliant with 12, partially compliant with 18 and non-compliant with six of them. An action plan had been drawn up to bring all recommendations into compliance with the hospital manager being listed as responsible for the overall plan of actions but there was no timeframe indicated on most of the actions. One of the actions was to re-establish a volunteer service, to be in place by end of Q4 2024. Inspectors were told that they were on target with this action. Inspectors noted that the Patient Advocacy and Liaison Service officer role was vacant at the time of this inspection and staff told inspectors that approval to fill the vacancy was being sought. Formal tracking and trending of complaints and sharing of learning was not yet in place at the hospital although the hospital service provider outlined plans to have this in place following additional training on the HSE complaints management system by year end.

Inspectors noted that complaints were reviewed at the ED specialty management team as part of the agenda. A 'Patient Story' was shared as part of the standard agenda for the executive management team although there was no evidence in the EMT minutes viewed by inspectors, that complaints were reviewed at that meeting.

In summary, inspectors found that service users' complaints and concerns were largely being responded to promptly, openly and effectively. Although improvement in the last two years was noted, it was unclear from documentation relating to the EMT, how or where complaints were reviewed at local level. Tracking and trending and formal sharing of feedback, although planned was not yet in place. There was room for further improvement in the turnaround times for complaint resolution.

Judgment: Substantially compliant

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.

This standard was marked partially compliant in the 2023 HIQA inspection. Inspectors followed up on the 2023 compliance plan and noted that of the nine actions planned to bring this standard into compliance, five had been completed and four were in progress. The hospital had upgraded an additional twenty five clinical hand-wash sinks to Health Building Notes (HBN)[†††] standards however, further work was needed to ensure that all

[†††] Health Building Notes (HBN) refers to Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf

relevant sinks met this standard as planned. Work was also yet to be completed on the audit of cleaning schedules and a plan to improve the monitoring of mandatory training.

The adult waiting area in the emergency department had been reconfigured since the last inspection and was now integrated with the main reception area. A staff security base was located nearby.

The waiting area comprised 61 seats. There were 11 people present in the waiting room at the time of inspection. The area was well-ventilated with open windows. There was a wheelchair accessible toilet and handwashing facility off the waiting area. There was access to refreshments via a vending machine in the waiting area. Posters outlining infection prevention and control messages and details on how to make a complaint or compliment to either the HSE's *Your Service Your Say'* or via the hospital local comment card system were clearly displayed in the waiting room area. There was a separate children-friendly waiting area which comprised 14 seats with access to cleanable toys, and a water fountain. There was a safeguarding statement on display. There were four children present and each was accompanied by an adult at the time of inspection. This area provided audio-visual separation as recommended in the national model of care for paediatric healthcare services. Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed. Staff were observed to be wearing PPE when indicated and stocks were visibly available as required. The 'bare below the elbow' practice was evident among all clinical staff seen.

The emergency department had a planned capacity for 26 service users comprising:

··two triage rooms and one post triage room
··four-bay ambulatory care or minor injury area (a fifth bay was used for storage of consumables)

- one room for eye examinations
- 10 adult 'major' bays, including two single rooms which could be used for isolation
- paediatric area comprising four cubicles, one of which was a single cubicle used for isolation if needed although, inspectors noted that there was no piped oxygen in this room and staff were reliant on oxygen cylinders.
- resuscitation area comprised four bays for the treatment of patients categorised as major. One double cubicle was set up for adult and paediatric resuscitation and there were two further single cubicles
- eight toilets in the emergency department for patients' use, two of which were located in the adult waiting area.

Although on a large footprint, the design, layout and adjacencies of the various areas within the ED were not intuitive and so involved heavier traffic than ought to be required. Inspectors were told that plans had been in place to re-purpose existing space in the ED in the coming weeks to help improve on this. In particular, the majors area was very congested and was in need of refurbishment. There was an area adjacent to the ED department which was being used as a discharge lounge during the inspection. The

hospital manager informed staff that this area was due to be transferred to the ED for use by the paediatric service in the coming weeks. The single cubicles in the ED did not have en-suite facilities and there was no neutral or negative pressure rooms in the department. There were no shower facilities within the ED but inspectors were told that patients could access shower facilities in the AAU by arrangement with staff if required.

Inspectors noted non-compliances such as, no splashback cover behind the sink in the toilet facility in the ED waiting room and so the plaster was exposed and chipped, the ECG machine and weighing scales located on the corridor in the minors area were dusty, a broken chair was noted on the corridor, the shredding bin in the workstation office of the minors area looked unclean with a shabby unlaminated notice applied, there was no lock and no temperature check in place on the drug fridge (which was powered on but was empty) in the same room. These issues were brought to the attention of the staff member (nurse) working in the area at this time. Paintwork was scuffed in the ambulance area. Although there was a top-up system of stores in place in the green storage zone, storage was noted on the floor. The issue of stores on the floor has been noted in previous HIQA inspection reports. Staff explained that clean equipment is tagged using 'I am clean' tags however, inspectors noted two wheelchairs that did not have those tags on, and were located in an area, from where ready-for-use equipment was drawn. The paediatric cardiac arrest trolley was noted to have been checked the previous day however, inspectors found that the ECG red dot electrodes had passed their expiry date. The adult cardiac arrest trolley contained a cardiac arrest policy dated 2015 and there was no checklist on the trolley. These matters were brought to the attention of the CNM2. The ECG electrodes were replaced immediately. Sharps boxes were signed and the apertures (lids) were closed. Disposable curtains were in use in the ED and had their dates of commencement of use recorded on them and those were clean and in date with the local policy for changing.

Medical North ward was a 30-bedded ward. Access to the ward was via a security fob and access to staff restricted areas was via a key code. The ward was full at the time of inspection and it was used to accommodate an additional three admitted patients on trolleys who were awaiting a bed. The ward comprised four six-bedded rooms each of which contained toilet and shower facilities, six single en-suite rooms and one additional bathroom on the ward. The doors of rooms in use for isolation were closed and appropriate signage was in use. Stocks of personal protective equipment were easily accessible. The corridors were tidy and clutter-free. A day room was maintained in a manner suitable for use by patients with dementia. It contained chairs which could convert into a bed if required and staff told inspectors that these were also used by family members who were remaining with a patient in the event of the patient being at end of life. Storage systems were in use for sterile products and these were clean and tidy. Overall the ward was clean and well maintained except for a store room which was used to store equipment and mattresses, which was cluttered and there was some chipping of paint and woodwork, especially on doors on the ward. Only some clinical hand-wash sinks were HBN compliant. Inspectors noted infographics on display relating to the WHO Five Moments of Hand Hygiene. Cleaning schedules for equipment and the environment were reviewed and there

were no gaps. Inspectors noted that lack of storage space was recorded on the ward risk register. There was a call bell in-situ for all patients on the ward with the exception of those on trolleys on the corridor. Staff told inspectors that patients were risk-assessed for suitability for placement on the corridor. A quality and education board was used to display results of audits conducted at ward level for example, compliance with INEWS.

The Childrens' ward, was an 18-bedded ward comprising one six-bedded ward, five isolation rooms and six cubicles which were used for cots only. Inspectors were told that if needed, up to 22 children could be accommodated on the ward. The ward was generally clean and tidy except for a cluttered store room which also contained inappropriate items. This was brought to the attention of the nurse in-charge. Only some of the clinical hand-wash sinks were HBN compliant and this was noted on the ward's risk register. Doors were closed on isolation rooms in line with policy and there was a stock of personal protective equipment easily accessible. The emergency number was clearly visible on all phones on the ward.

In summary, while there has been an improvement to integrate the waiting room with access to staff at registration, the overall layout and design of the ED footprint did not support the patient flow resulting in increased traffic by staff. The majors area was very congested, even without the addition of the trolleys for admitted patients along the corridor, and it was also in need of refurbishment. The placement of patients on trolleys in corridors both in the ED and on the ward meant that those patients did not have access to a call bell but were risk-assessed in advance of placement. While the ward areas were largely clean and tidy, store rooms were found to be cluttered and some storage was found on the floor in the ED.

Judgment: Partially compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.

This standard was assessed as partially compliant in the 2023 HIQA inspection. Inspectors followed up on the 2023 compliance plan and noted that all three actions planned to bring this standard into compliance had been completed and that a clinical audit coordinator had been recruited earlier in the year. Hand Hygiene training continued to be offered to all staff.

Inspectors viewed documentation relating to monitoring the effectiveness of healthcare in the inspected areas. Audits conducted on the quality of nursing care provided to admitted patients on trolleys in January 2023 and of post-triage nursing documentation conducted in the ED in July 2023 led to the development of a revised booklet to record nursing observation and care. Inspectors noted that the hospital was more recently using

the HSE *Test your Care Metrics* and results for year to date from quarterly audits conducted in February, May and September 2024 were provided for the ED. Compliance with medication safety KPIs in 2024 was noted to be 100%, however, compliance with use of the early warning systems and the use of ISBAR (the communication tool used for handover of care and or when seeking advice or requesting a review of a patient) was in need of attention with scores of only up to 67%.

Inspectors viewed audits conducted in the ED relating to the WHO *Five Moments of Hand Hygiene* (result: 70% in July 2024 which did not meet the HSE target of 90%), environmental hygiene (result: 87.7%) in August 2024 and equipment hygiene (result: 86%) in September 2024. While issues of non-compliance were highlighted, there was no evidence of an assigned responsible person or timeframe for completion of actions on the audit reports apart from the environmental hygiene audits dated October 2023 (result: 89%) and January 2024 (result: not recorded).

Audits were conducted on the WHO *Five Moments of Hand Hygiene* in the Medical North ward and results were provided for June 2023 (result: 87%), November 2023 (result: 63%) and August 2024 (result: 83.3%), all of which did not meet the HSE target of 90%. While issues of non-compliance were highlighted, there was no evidence of an assigned responsible person or timeframe for completion of actions on the audit reports. Environmental hygiene audits were conducted in May 2024 (result: 79.2%) in June 2024 (result: 94%) and September 2024 (result: 92%). Issues of non-compliance were highlighted and an assigned responsible person was identified in only one audit. There were no timeframes recorded for actions. An audit of equipment hygiene in September 2024 was 97% compliant.

Inspectors were told about a medication safety audit undertaken against national guidance around the use of direct oral anti-coagulants (DOAC). Learning from the audit was shared with staff and staff had access to a dedicated bleep number for a pharmacist regarding anticoagulation treatment. Audits were also being undertaken by pharmacy staff into insulin prescribing for diabetics. Monthly chart audits were being conducted by both clinical nurse managers and non-consultant hospital doctors. Results were reviewed by the deteriorating committee and actions taken on non-compliance such as provision of training. This is evidence of good practice.

An audit of nursing shift handover for staff was conducted in Medical North ward in June 2023. The overall level of compliance was found to be 68% and a quality improvement plan was put in place in August 2023 including plans to provide education to staff, development of templates for Safety Pauses, ISBAR clinical handover and safety huddles. Further audits of compliance with use of the INEWS and ISBAR by staff were conducted on Medical North ward in January, February, March and July 2024 when compliance reached 93% on *Test your Care* metrics. Non-compliances were brought to the attention of the ward staff, education was provided and were highlighted at safety pauses.

Progress was noted although there continued to be some non-compliances by July 2024 for example, the sepsis form was not used as part of escalation.

Audits were conducted in the paediatric ward relating to the WHO *Five Moments of Hand Hygiene* (result: 73% in June 2024 which did not meet the HSE target of 90%). Audits from the *Test your Care* metrics on key performance indicators relating to medication safety were conducted on the Children's ward in June, July and August 2024 and resulted in scores of 92%, 97% and 87% respectively. The Deteriorating Paediatric Patient Committee had a quality improvement plan in place dated September 2024 covering governance, pathways, transfers, tools including ISBAR clinical handover, PEWS, safety huddles, whiteboards and fluid balance charts with assigned responsible persons and timeframes for completion.

Inspectors viewed the results of an audit conducted in March 2024 and repeated in April 2024 into the care of the paediatric patient in the ED. These audits focused on the five following objectives:

- paediatric patients to spend no more than four hours in the ED once seen by a clinician (4-hour target)
- the paediatric early warning system to be used in the case of all children in the ED post triage
- adherence by staff to the PEWS escalation guide
- the initiation of sepsis forms in line with hospital and national guidance and
- the requirement by staff to undertake and record a recent set of vital signs and the calculated PEWS score prior to discharge from the hospital.

The initial audit contained recommendations and a quality improvement plan based on findings. A repeat audit showed improvements in some but not all areas and further recommendations and a quality improvement plan were recorded. An updated quality improvement plan dated October 2024 was reviewed by inspectors who noted that of the 24 listed actions, 13 had been completed, nine were in progress and two had yet to be commenced. These included assurance of compliance with attendance at PEWS training and a plan to increase the ratio of paediatric trained nurses among ED nurse staffing.

In summary, inspectors heard from staff and viewed documentation relating to audit activity in all three inspected areas. While there was evidence of ongoing audits and evidence of good practice, for example, the establishment of a specific means of contact with a pharmacist in relation to anticoagulant therapy, there was a lack of documented quality improvement plans with tangible actions, responsible persons and timeframes in which to demonstrate improvement over time. As a result, limited progress from results of ongoing audits was shown in some areas.

Judgment: Partially Compliant

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services

This standard was assessed as partially compliant in the 2023 HIQA inspection. Inspectors followed up on the 2023 compliance plan and noted that of the seven actions planned to bring this standard into compliance, all but one had been implemented. This related to approval being sought for the initiation of a capital project to increase capacity of the aseptic compounding unit in the pharmacy. Inspectors were told that initial feasibility studies were underway by the HSE National Estates lead and that it was still under discussion.

The quality and safety executive committee (QSEC) which met four to six weekly and reported to the executive management committee (EMT) were responsible for recording, managing and reviewing the risks on the hospital's corporate risk register. Quality and patient safety staff supported ward managers and or heads of department in developing and maintaining local risk registers. The inspected ward areas had department risk registers. For example, inspectors viewed the paediatric department risk register which was reviewed on an annual basis in May by the specialty multidisciplinary team and overseen by the quality and safety executive committee. It contained 23 risks covering staffing, facilities and equipment. They were all risk rated, had existing control measures and additional control measures documented. Items not manageable at local level were escalated to the corporate risk register and items not manageable at hospital level were escalated to the HSE WNW.

Inspectors viewed the hospital corporate risk register dated July 2024. It listed 15 risks, all of which had an assigned risk owner, were risk rated and had existing control measures documented. They covered aspects including: the impact of delayed patient flow through the ED, equipment issues, lack of capacity for diagnostics - CT in particular, staffing deficits particularly in the laboratory, physiotherapy and in medical social work, infrastructural issues including IT, infection prevention and control issues, suboptimal clinical handover, and increase in ambulance turnaround times. All risks on the hospital's corporate risk register were discussed at the quality and safety executive committee (QSEC) meetings and escalated to the EMT. Staff spoke with inspectors about the impact of old IT systems particularly in relation to the effective functioning of laboratory and other services, the inability to increase the number of network points due to licensing issues and the number and length of passwords required on multiple occasions on a daily basis to access systems for work. This was a documented risk on the corporate risk register dated July 2024. Existing controls included a planned upgrade which was anticipated to take at least 18 months once approved but the hospital had not yet received the approval at the time of the inspection. The hospital had rolled out a digital dictation system since the last HIQA inspection which was an improvement.

Infection Prevention and Control

The Infection Prevention and Control Committee maintained a risk register which was reviewed at QSEC meetings. Infection prevention and control incidents were reported to NIMS and tracked and trended by the Quality and Patient Safety department who circulated them to the IPC committee. An outbreak committee comprising a multidisciplinary team was established in the event of an outbreak. Inspectors viewed minutes of the most recent outbreak team meeting where current status, review of any issues and decisions were all clearly documented in the minutes of the most recent outbreak committee. The IPC team had input into method statements prior to building works within the hospital. Staff told inspectors of one exception to this, where another service on the campus which was not under the governance of SUH, had recently undertaken significant building works but had not collaborated with the infection prevention and control team in SUH in advance. The matter was raised and dealt with by hospital management and the IPC team on commencement of the works.

Compliance with the WHO *Five Moments of Hand Hygiene* was reported at least annually to the HSPC and was 87.6% in October - November 2023. This was the same result as in October - November 2022. Inspectors noted that it had not reached the HSE target of 90% or over since late 2021 when it was 91%. Inspectors viewed the quality improvement plan dated September 2024. It had been devised by the infection prevention and control team to focus attention on improving compliance by increasing the frequency of in-house training, providing ward based education, encouraging uptake of online education using HSELanD, using the hand hygiene scanner to raise awareness, and providing a train the trainer event, ensuring access to staff from wards where there was a recent CPE outbreak. Eight staff were booked onto this train the trainer course and eight staff had been trained on this earlier in the year.

The hospital were monitoring compliance with screening for Carbapenemase Producing *Enterobacterales* (CPE) by ward area. Compliance with CPE screening of admitted patients on the inspected areas for the first eight months of the year was averaging 94% in Medical North and 25% in the Children's ward. Inspectors viewed the quality improvement plan dated September 2024, devised by the infection prevention and control team to focus attention on improving compliance with screening for CPE and seeking to reduce the risk of transmission. This included enhanced environmental monitoring, introduction of checklists for ward staff to help identify those who should be offered screening and why, and ongoing audit of compliance with offer and uptake of CPE screening. The risk of healthcare acquired infections including COVID-19, VRE, CPE and Clostridium difficile due to ageing infrastructure and lack of isolation facilities was also noted. Staff told inspectors about a proposed multi-service block which was in the design phase.

Medication Safety

Pharmacy staffing was an issue in that not all wards had cover from a clinical pharmacist. The ICU had cover from a clinical pharmacist, the ED did not. A risk assessment had been

undertaken and controls put in place to help mitigate risk and it was escalated to the corporate risk register. The hospital did not have a formulary. Requests for new medications were sent to the DTSC and these were also reviewed by the finance department and lastly by the EMT.

Medication safety was supported by the medication safety policy. Medicine reconciliation was conducted by the clinical pharmacist on newly admitted patients and or patients transferred in from another ward - using two verifiable sources of information. However, not all wards had a clinical pharmacist although support could be sought from pharmacy by telephone. Risk reduction strategies were noted, for example, separation of storage of intravenous fluids containing potassium, restricted use of intravenous iron, and the use of posters with a list of 'sound alike, look alike drugs' (SALADS) on display in the treatment room to alert staff to such risks in identification. Staff could also bleep a clinical pharmacist to speak with patients commencing anti-coagulation therapy. Staff had access to an online medication safety resource. Hard copies of the British National Formulary were available on the medication trolley in Medical North ward. One was dated September 2024, however the remainder were out of date. This was brought to the attention of the staff member present and they were removed immediately. Antimicrobial guidance was also available on this ward but was undated. A specific app for medication safety for children was available on the desktops and mobile phones of staff working with children. Controlled drugs were appropriately stored in the three clinical areas inspected. The hospital had 60 registered nurse prescribers in place and inspectors were told that they participated both in self and peer audits, there were overseen by the nursing practice development department.

Deteriorating Patient

Risks to timely quality of care for patients in the ED was documented on the risk register with a list of existing controls identified. Inspectors noted that patients on trolleys being cared for on the corridor in the ED did not have access to a call bell. Staff told inspectors that their condition was used to determine their location and that a nurse or healthcare assistant was allocated to provide support and care of these patients.

The hospital was using the national early warning systems relevant to the various cohorts of patients (adult and emergency, paediatric and maternity), the Sepsis 6 care bundle, and the ISBAR communication tool. Policies and procedures were in place including when and how to escalate concerns about a patient's status. A cardiac arrest team was available 24/7 and accessible through a standard bleep system. Risks relating to increased morbidity and mortality for patients were outlined on the corporate risk register. The deteriorating patient committee representatives spoke with inspectors about how although the paediatric early warning system (PEWS) was designed for use with children who were admitted, SUH had implemented its use on all children who remained in hospital four hours post triage and SUH had also commenced the requirement for a second set of observations on a child who was being discharged from

ED. The safety pause template was being piloted with a plan to reflect any changes in a revised policy for the safety pause. There was a pathway in place for patients requiring transfer to tertiary centres and inspectors heard how there was a suite of education and simulated training being provided to staff both on HSeLanD and in person across the HSE WNW region. As part of wellbeing and inclusion, the hospital were designing clinical handover templates that were easy to use by all including those with dyslexia. This is a commendable action.

Transitions of Care

The risk of suboptimal care being provided to patients due to lack of formalised clinical handover and ineffective communication of critical information in some areas of the hospital was documented on the corporate risk register. To help mitigate the risk, a clinical handover steering group was established and the hospital had a clinical handover policy in place. It was noted that clinical handover among nursing staff took place at each shift handover in all areas of the hospital, and clinical handover was in place for many but not all specialties. Responsibility for hospital wide compliance with the handover policy was placed with the associate clinical directors and a timeframe of December 2024.

The risk of an increased length of stay due to shortages among health and social care professionals, in particular in physiotherapy and in medical social work was also recorded on the corporate risk register. At the time of inspection, the hospital manager was continuing to seek approval to recruit. In the meantime, physiotherapy department had suspended or curtailed services, for example the physiotherapy outpatient clinics for ED, maternity and the chronic obstructive pulmonary disease (COPD) respiratory services had been suspended while the physiotherapy services in the frailty intervention team (FIT) in ED, and in the orthopaedic clinics had been reduced. The physiotherapy department had developed a prioritisation system to help ensure that the most critical needs were addressed first. The medical social work had also developed a prioritisation system to help ensure that the most critical needs were addressed first. Ward managers, consultant staff and the discharge facilitator had been alerted to the ongoing shortage in medical social work.

Posters on adult safeguarding were noted on display in Medical Ward North. Staff were knowledgeable in the steps taken to identify and manage or escalate risk including documentation of risk assessments. Support was available through line management structures and access to the on-site ADON. Inspectors viewed a sample of risk assessments and found that these were completed in line with national guidance. Staff reported receiving reports on incidents from the quality and safety department and of training provided to ward managers on risk management.

Inspectors noted that in some cases, the risks as outlined in the hospital risk register were realised, in particular in relation to the risk to quality and safety of care provided in an overcrowded ED where PETs are breached. Extended length of stay in the ED is

associated with higher morbidity and mortality rates for patients in that situation. The risks relating to infection prevention and control were also not fully mitigated particularly where the hospital has failed to meet the HSE targets for compliance with hand hygiene over a two year period and compliance with mandatory training was not being met, as outlined under national standard 6.1.

In summary, inspectors found that on this inspection, although the hospital was identifying risks and seeking to mitigate those, and there was evidence of positive developments in practice, more work is needed across a range of areas including infrastructure, IT and staffing to protect service users from the risk of harm associated with the design and delivery of healthcare services.

Judgment: Partially compliant

Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.

Inspectors noted that patient safety incidents were being identified, managed, responded to and reported. The hospital used the NIMS electronic point of entry to reports incidents.

Staff who spoke with inspectors demonstrated good knowledge about what, when, and how to report a clinical incident. Incidents were tracked and trended using national policy and guidelines, An incident summary report was submitted at the monthly quality and safety executive committee (QSEC) and at bi-monthly HSW WNW meetings which identified extreme and or major incidents as a percentage of all incidents. The national policy and guidelines were used for audit of practice.

Copies of tracking and trending the findings of incidents specific to a directorate were shared with the directorates and with the nursing practice development unit (NPDU) by the quality and safety executive committee for further dissemination and action where required. Ward managers received reports of clinical incidents on a monthly basis and inspectors heard how learning was shared at staff meetings and at safety huddles.

Medication safety incidents were reported to NIMs and tracked and trended and reviewed by the drugs and therapeutics committee who decided on risk management and or corrective actions including changes in policy or practice following an incident. For example, following incidents relating to the administration of a particular infused medication, it was restricted to be administered during core hours and or only when there was adequate staffing in place to provide the necessary supervision of the patient. The incident was also reported to the relevant bodies.

Inspectors sought updates on a sample of incidents and noted that these were progressing, in that where investigations had already been completed, examples were provided of recommendations which had been implemented.

The published hospital patient safety indicator reports (HPSIR) for 2024 were reviewed for Sligo University Hospital (SUH). Inspectors spoke with staff about the fact that the monthly published HPSIR reports for clinical incidents per 1000 bed days was blank up to the point of this inspection. The QPS staff reported that clinical incident reporting was good. Inspectors noted that the data was subsequently reported from January up to July 2024 in the October 2024 published HPSIR report. The expected range of clinical incident reports to NIMS per 1000 bed days was 5.80 to 48.0. The actual rate of reporting clinical incidents by Sligo University Hospital averaged at 24 per month from January - July 2024 inclusive. This was an increase from 15.34 in 2023 and 17.5 in 2022. An increase in reporting clinical incidents is considered a positive aspect of risk and incident management. Inspectors viewed documentation which showed that over 95% of incidents were being reported to NIMS within 30 days of occurrence, meeting the HSE target of at least 70%.

In summary, inspectors found that the hospital staff were effectively identifying, managing, responding to and reporting on patient-safety incidents.

Judgment: Compliant

Conclusion

HIQA carried out an unannounced inspection of Sligo University Hospital on 08 and 09 of October 2024 to assess compliance with national standards from the *National Standards for Safer Better Health*. The inspection focused on four areas of known harm – infection prevention and control, medication safety, deteriorating patient and transitions of care. The inspection included follow-up of the compliance plan submitted by the hospital in respect of partial and non-compliances as found in eight national standards during the unannounced emergency department inspection in 2023.

In summary, inspectors found that the hospital was compliant with three National Standards (5.8, 1.7 and 3.3), substantially compliant with two National Standards (5.2 and 1.8) and partially compliant with six National Standards (5.5, 6.1, 1.6, 2.7, 2.8 and 3.1) While there was evidence of some progress in achieving objectives and an understanding that further work remained to be completed, there was not enough progress to positively impact on the hospital's compliance with the *National Standards for Safer Better Health*.

Capacity and Capability

Sligo University Hospital had formalised integrated corporate and clinical governance arrangements in place which were appropriate for the size, scope and complexity of the service provided. Inspectors noted that this was the third inspection in the last three years of Sligo University Hospital. Inspectors noted that despite efforts being made by hospital staff to examine and address the causes and contributing factors leading to ongoing delays in the rate of patient flow through the ED and the time intervals between the various points of care, little progress in reducing the patient experience times was seen on inspection with the exception of the patient experience times for the non-admitted patients - presenting in the ED. All of the HSE targets for patient experience times were breached on the day of inspection and inspectors noted that this was an ongoing issue. This meant that patients waited too long to be seen in triage and too long to be admitted or discharged. As a result, the ED was overcrowded and was being used to accommodate admitted patients. The acute assessment unit was also being used to accommodate admitted patients which in turn impacted upon its performance and efficiency in seeing, treating and or admitting patients. This requires significant and ongoing efforts to ensure that patients can access emergency care and can either be discharged or admitted to a hospital bed on a ward in a timely manner.

The hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. Inspectors noted that there were overall improvements in recruitment of staff since the last inspection although there continued to be a shortfall in areas such as health and social care professionals and laboratory staff. There was very little progress noted overall in the compliance with attendance at mandatory training as required in line with national guidance. This had been highlighted in the HIQA inspection in 2023. It is essential that hospital management ensures that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

Quality and Safety

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the hospital including in the emergency department. Staff were observed, promoting a culture of kindness, consideration and respect. Patients who spoke with inspectors were complimentary of staff, and of care given however, they pointed out the shortcomings of being on a trolley in the corridor of ED instead of a hospital bed. They referred to the noise and the use of bright lights. Inspectors noted there was no significant improvement in the ED environment where admitted patients (for who there was no available bed) were cared for, since HIQA's previous inspection in 2023. This impacted on any meaningful promotion of the patient's dignity, privacy and autonomy and was not

consistent with the human rights-based approach to care supported and promoted by HIQA.

Inspectors found that service users' complaints and concerns were largely being responded to promptly, openly and effectively. There was room for further improvement in the turnaround times for complaint resolution. Tracking and trending and formal sharing of feedback was not yet in place although the hospital service provider outlined plans to have this in place following additional training on the HSE complaints management system by year end.

Inspectors noted the improvement made to integrate the waiting room with access to staff at registration. The overall layout and design of the ED footprint however, did not support the patient flow resulting in increased traffic by staff. The majors area was very congested, even without the addition of the trolleys for admitted patients along the corridor, and it was in need of refurbishment. The ward areas, Medical North and the Children's ward were clean and tidy although inspectors noted that some storeroom areas were very cluttered. While there was evidence of ongoing audits, there was a lack of documented quality improvement plans with tangible actions, responsible persons and timeframes in which to demonstrate improvement. Limited progress in results of ongoing audits was shown in some areas. Although the hospital had systems in place to identify, mitigate and manage risk, more work was needed to protect service users from the risk of harm associated with the design and delivery of healthcare services. Inspectors noted that some of the identified risks had been realised and resulted in incidents.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in implementing the short-, medium- and long-term actions being employed to bring the hospital into full compliance with the national standards assessed during inspection. It is imperative that action occurs following this inspection to address inspectors' findings at the hospital, in the best interest of the patients that the hospital serves.

Appendix 1 – Compliance classification and full list of standards considered under each dimension and theme and compliance judgment findings

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the national standards is identified, a compliance plan was issued by HIQA to the service provider. In the compliance plan, management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the progress in implementing the action(s) set out in any compliance plan submitted.

HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially compliant
Standard 5.8 Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance plan provider's response:

Standard	Judgment
National Standard 5.5 Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially Compliant

Outline how you are going to improve compliance with this national standard:

- ED QIP Senior Hospital group established to focus on PET times in ED, actions and progress reports are reported to UPPG Committee on a monthly basis Status: Complete
  (Responsible person: Chair of ED QIP group/Senior Hospital Management/GM for Group Unscheduled Care)

- Develop and implement SOP for management and monitoring of triage times by ED
  Status: Complete
  (Responsible person: Consultants in Emergency Medicine/ADON for Unscheduled Care/ED CNM III)

- Enhance and implement SOP for Safety Huddles, incorporating attendance by Operational ADON, Consultant in Emergency Medicine on-call and/or designate. Additional safety will be incorporated at 11pm to increase situational awareness. A further safety huddle called by the CNM II in charge in consultation with the Operational Nurse Manager, where necessary. Safety huddle records to be maintained, with documented actions as per ED Escalation framework to identify any immediate concerns and actions required. Safety Huddle will also include focus on triage categories
  Status: Complete
  (Responsible person: Consultant in Emergency Medicine/ADON for Unscheduled Care/ED CNM III)

- Consultant in Emergency Medicine designated to manage and co-ordinate activities in Minors and Rapid Assessment, Monday to Friday
  Status: Complete

(Responsible person: Consultant in Emergency Medicine)

- Continue observational audit of time to triage
  Status: Ongoing.
  (Responsible person: ADON for Unscheduled care/ED CNM III/ Clinical Skills facilitator)

- Install additional screens for visual display of ED wait time dashboard for ease of monitoring and management by all relevant clinical staff
  Status: complete
  (Responsible person: Clinical Project Manager/ICT Manager/Systemview Lead)
- Include "first seen by" treating clinician and "last seen by" treating clinician timestamps in ED Situation Report Patient List on SystemView
  Status: Complete
  (Responsible person: Clinical Project Manager/Systemview Lead)

- Senior Management Team will meet at the Navigational hub twice a day with a focus on PETS
  Status: Complete.
  (Responsible person: Hospital Manager/ ADON for Patient Flow)

- Screen to be set up in Bed Management /Navigational hub to give overview of waiting times in the Emergency department from HPVP - Q3 2025
  (Responsible person: ADON for Patient Flow)

- Improve co-horting of admitted 75+ year patients to an acute frailty inpatient unit. Establish working group to oversee clinical/operational procedures, to include criteria that assess with Emergency department flow - Q4 2025
  (Responsible person: Cons Geriatrician/Consultant in Emergency Medicine/ADON for Patient Flow/ADON for Unscheduled care/ED CNM III/ADON for Medical)

- Establish a more robust minor injuries streaming system in ED. Working group in progress and SOP to be written for implementation of safe and effective streaming - Q3 2025
  (Responsible person: Consultants in Emergency Medicine/ ADON for Unscheduled Care)

- Agree and develop rapid response process and pathway from sub-specialties for ED attendances, ie Ortho and Surgical - Q4 2025
  (Responsible person: Consultants in Emergency Medicine, Peri-Op)

- Undertake a review nursing roster to ensure additional resource is allocated to triage at peak attendance days (particularly Monday and Friday) ensuring a minimum of 2 nurses are assigned at all times with third nurse to ensure cover for break periods
  Status: Complete.
  (Responsible person: ADON for Unscheduled Care/ED CNM III)

- Improve safety and skill mix of nurse staffing levels in ED at night through the implementation of roster change with equal number of skill mix for days and nights
  Status: Complete
  (Responsible person: ADON for Unscheduled Care/ED CNM III)

- Amend Emergency Department's NCHD roster to include 2nd oncall registrar on Monday night for peak times and 1 extra SHO Friday night. Also review roster arrangement to increase

medical SHO resources for Emergency Department on Monday, Tuesday and Friday evenings from January 2025
Status: Complete.
(Responsible person: Consultants in Emergency Medicine)

- Ring fence HCA or Nurse resource for post triage observation and escalation to registered nurse for patient's waiting clinical assessment
  Status: Complete - staff dependent.
  (Responsible person: ADON for Unscheduled care/ED CNM III)

- Progress with recruitment of SAFER staffing posts in ED while awaiting national primary notification numbers
  Status: Complete
  Continue re-evaluation of safer staffing to incorporate 2024 stats
  Status: ongoing
  (Responsible person: ADON for Unscheduled Care/ED CNM III/HR Manager)

- Roster two additional ANP's for Paeds and Minors Area from January 2025 to assist with clinical assessment times
  Status: complete
  (Responsible person: ADON for Unscheduled care/ED CNM III)

- Ensure full PFC staffing compliant. 5th PFC post to be recruited to ensure cover for Bed Management, Patient Flow in hours (and OOH from August BH, 2025), discharge coordinator leave and OPAT clinics, Q3 2025 Focus on >14/7 LOS weekly, recruit 5th PFC post, to allow team with focus on >7/7 LOS. Train 2nd PFC as Discharge co-ordinator - Q4 2025
  (Responsible person: ADON for Patient Flow)

- Increase Consultant Geriatrician presence in ED, current status Mon/Tues/Thurs/Saturday (one in 8) covered by Consultant Geriatrician, Wed and Thursday covered by Registrar with availability with Consultant Geriatrician, Status: Complete.
  (Responsible person: ACD for Medical Directorate)

- Open Acute Assessment Unit zone functioning with 4 bays/target of 14 patients per day, Review pathways for emergency attendances through enhanced use of Acute Assessment Unit
  Status: Complete
  (Responsible person: Consultants in Emergency Medicine/ADON for Patient Flow/ED CNM III/ADON for Unscheduled care)

- Improve Emergency Department flow through department with the opening of a new Paeds ED department and to comply with standard on completing audio and visual separation. Previous paediatric waiting area in ED to become a temporary sub-waiting area, for times of escalation. Former Paediatric clinical area to function as an emergency frailty unit (EFU)
  Status: Complete
  (Responsible person: ADON for Patient Flow/ADON for Unscheduled Care)

- Open and operationalise 26 off-site acute beds
  Status: Complete.
  (Responsible person: Clinical Project Manager/Project team)

- New minutes recording template to be circulated to all committee chairs requesting implementation of same to ensure minutes are action led & time bound - Q3 2025
  (Responsible person: Assistant Hospital Manager)

- Progress with Capital development for 42 bed additional capacity, increase CT service and Day Oncology capacity. Contractor to be on site by Q3 2025
  (Responsible person: HSE Estates team)

Timescale:

National Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially Compliant

Outline how you are going to improve compliance with this national standard

- HR will implement a management of attendance plan with all Line Managers, through issuing reminders monthly regarding return to work meetings / and requesting information to be forwarded to HR. Also HR will commence information sessions regarding sick leave / managing attendance / return to work meetings alongside HSE webinars scheduled regarding managing attendance, which HR will encourage line managers to attend - Q4 2025
  (Responsible person: HR Manager)

- PALS Officer to be recruited and in post
  Status: Complete
  (Responsible person: Quality & Safety Manager)

- Assign Grade VI Compliance Support Officer responsibility for monitoring and managing training statistics across all mandatory training areas. The officer will ensure that full compliance is maintained at all times and will provide regular reports directly to the Assistant Hospital Manager and the HR Manager - Q4 2025
  (Responsible person: Assistant Hospital Manager/HR Manager)

- Implement E-Rostering for Nursing to capture mandatory stats – Q4 2025
  (Responsible Person: Director of Nursing/HR Manager)

- Enhance clinical handover and senior decision making presence on ED floor over seven days. 8th ED Consultant to be filled on a temporary basis, with the ECC escalated to IHA Manager
  Status: Complete
  (Responsible person: Consultants in Emergency medicine /Hospital Manager/Medical Manpower Manager)

- Recruit IPC CNS post - Q3 2025
  (Responsible person: Director of Nursing/HR Manager)

- HR / Hospital Management will continue to escalate urgent 2023 vacancies for derogation, to include FIT team members, SLT / Pharmacist, and ED Phlebotomy and HCA posts - Q4 2025
  (Responsible person: Hospital Manager/HR Manager)

- Medical Manpower will ensure full compliance with 'Escalation Protocol for Prior Approval of the Employment of any Consultant not on the Specialist Division of the Register of the Medical Council
  Status: Complete
  (Responsible person: Medical Manpower Manager)

- SUH PEWS training schedule in place for Nurses & Doctors (Face to face for first time attendees. SUH PEWS refresher training available on Hseland (2 yearly)
  Status: Ongoing
  (Responsible person: ADON for Nurse Practice /ADON for Paediatrics/Chair of DPIP Committee)

- Ensure 90%+ compliance at SEPSIS training for all relevant staff, ensuring all staff complete programme. Appoint Nurse lead for Sepsis across the hospital. Supplementary training (Sepsis/INEWS) to be available every week for nursing and HCA staff.
  Status: Ongoing
  (Responsible person: Consultants in Emergency Medicine/ADON for Unscheduled Care /CNM III)

- All nursing staff assigned to triage are required to have up-to-date Manchester triage training. Manchester triage refresh training to be completed by all relevant staff to ensure 100% compliance - Q3 2025
  (Responsible person: ADON for Unscheduled care/ED CNM III)

- Implement SEPSIS prompt at triage stage on IPMS - Q4 2025
  (Responsible person: IPMS Lead/CNM III ED/Quality & Safety Manager)

Timescale:

National Standard 1.6 Service users' dignity, privacy and autonomy are respected and promoted.	Partially Compliant

Outline how you are going to improve compliance with this national standard

- PALS Officer in post and rolling out clear information in the form of information leaflets outlining the service and posters for display in all acute ward areas / unscheduled care areas and OPD
  - The Your Service Your Say leaflets and posters for both adults and children to be available in all areas.
  - Engage with the Patient Advocacy Service to request posters on their services
  - PALS Officer will also engage with local advocacy services such as Sage / Cairde / EPIC / Inclusion Ireland and advise that the PALS service is available in SUH - Q2 2025

  (Responsible person: PALS Officer)

- Painting regime to be put in place in the Emergency Department (Major area), corridors, family room, ambulance area and to include wall protection, to improve overall aesthetics in the department and rationalise storage - Q3 2025
  (Responsible person: Maintenance Manager/ ADON for Unscheduled care)

- Progress refurbishment of Psych room and family room in ED Department – Q4 2025
  (Responsible Person: Estates Team)

- Remove patients on trollies from front corridor by creating additional adult space in ED by moving Paediatric patents to vacant zone.
  Status: Complete
  (Responsible Person: ADoN for Unscheduled Care)

Timescale:

National Standard 2.7 Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant

Outline how you are going to improve compliance with this national standard

- Remedial work on Paediatric ward- Plinths put in place to ensure storage of items off the floor, complete. Reconfiguration of storage on ward - Q3 2025
  (Responsible person: ADON for Paediatrics)

- Continue the upgrade of remaining sinks to HBN Standards across the Hospital, to include total removal of non-standard sinks in some area - Q4 2025
  (Responsible person: ADON for Infection Prevention & Control/ Maintenance Manager)

- Remedial works to be actioned that were outlined in the report, i.e. paint/woodwork damage on Medical North, storage issues, checks on drug fridge, i.e. lock and temperature checks, splashback cover for toilet facility in ED – Q3 2025
  (Responsible person: Maintenance Manager)

- Review to be undertaken of cardiac arrest trollies, to ensure that equipment and policy are up to date - Q3 2025
  (Responsible person: Resuscitation Officer)

- Upgrade one 6-bedded area to include the bathroom area, in each of the following areas: Surgical North, Oncology, & Medical South - Q2 2025
  (Responsible person: Maintenance Manager)

- Review storage capacity in ED and prioritise moving storage from floor area – Q3 2025
  (Responsible Person: Procurement Officer / ADoN for Unscheduled Care)

Timescale:

National Standard 2.8 The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially Compliant

Outline how you are going to improve compliance with this national standard.

- Review ISBAR Tool and process to include new format for documentation and to rollout education to doctors and nurses – Q3 2025
  (Responsible Person: Chair of DPIP committee/ADoN for NMPDU)

- Need to monitor resources and actions on admitted PETS through ED Improvement working group. Monthly updates to be forwarded to UPPG monthly meetings with focus on triage and PET times
  Status: Complete
  (Responsible person: Hospital Manager/ ADON for Patient Flow)
- Infection Prevention & Control Committee to oversee Hand hygiene audit results, review action plans from areas that are not meeting > 90% compliance to ensure actions have responsible person and are time-bound - Q3 2025
    - Continue to roll out the Train the trainer programme for Hand Hygiene and identify hand hygiene champions per area - Q3 2025
    - Attendance at mandatory Hand Hygiene to be improved by promoting on line attendance via hseland.ie as per HR Memo 043/2024 - Mandatory Hand Hygiene Programme - Q3 2025

  (Responsible person: Asst General Manager / ADON for IPC)

- Hygiene committee to oversee hygiene results and ensure that areas that are not meeting the > 90% have an action plan with responsible person and time-bound. Hygiene audit reports will be brought to IPC Committee - Q3 2025.
    - QIP training will be rolled out for all staff using the Hygiene automated audit tool – MEG - Q4 2025

  (Responsible person: Hygiene Co-ordinator)

- Clinical audit co-ordinator will establish a Sharefile for all audits in process or completed in SUH. Clinical audit documentation will be available on HCI and Hospital buddy. Continuous promotion of clinical audit guidance will be available through teaching sessions. These initiatives will be under the governance of the Clinical audit committee - Q3 2025
  (Responsible person: Clinical audit co-ordinator)

- New QIP recording template to be circulated to all committee chairs requesting implementation of same to ensure QIPs are action led & time bound - Q3 2025
  (Responsible person: Assistant Hospital Manager)

- MDA audit tool to be revised and updated in line with new Medication management policy, with ongoing work to add tool to MEG platform - Q4 2025
  (Responsible person: ADON for Patient Flow/Drugs & Therapies Committee Chair)

- Oversight of complaints;
  - Review of systems and mechanisms for receiving complaints in SUH
  - SOP to be drawn up around the process when a formal complaint is received to an individual department
  - Communication of this SOP to all departments in SUH
  - Ensure each complaint received is logged on the Complaints management system
  - Hospital wide education on HSE Your service your say, The management of service user feedback for comments, compliments and complaints, 2017, to include the management of stage 1 and stage 2 complaints.
  - Weekly Consumer service office meeting to review complaints and progress on same
  - Produce quarterly reports to summarise complaints by type, department, resolution status and trends.
  - Annual audit to assess compliance with national policy, resolution effectiveness, and system weaknesses - Q 3 2025

  (Responsible person: Consumer services manager)

Timescale:

National Standard 3.1 Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant

Outline how you are going to improve compliance with this national standard.

- Regular communication to remind managers of their responsibility to comply with CPE screening
  Status: Complete/Ongoing
  (Responsible person: ADON for IPC)

- Regular communication to remind managers of their responsibility to ensure all staff comply with Hand hygiene training. Hand Hygiene non compliances to be escalated to Line Managers on a quarterly basis by HR Department – Q3 2025
  (Responsible person: ADON for IPC/HR Manager)

- Development of a prompt sheet for 'expected information' from ward area to Operational ADON/CNM3, that is required to escalate clinical/operational matters, including deteriorating patients. Also develop guidelines for the Operational ADON role - Q3 2025
  (Responsible person: ADON for Nurse Practice/ Director of Nursing)

- Progress with capital projects such as;
  - ED Psych room - Q4 2025
  - Renal 4 bay area - Q3 2025
  - CSSD upgrade - Complete
  - Operationalise 2nd CT - Complete
  - ICT infrastructure and Network upgrade, processing to Stage 2b detailed stage - Complete
    – to include Telemetry - Complete

  (Responsible person: Estates Team/Hospital Management)
- Progress with Capital development for 42 bed additional capacity, increase CT service and Day Oncology capacity. Contractor to be on site by Q3 2025
  (Responsible person: HSE Estates team)

- Apply for AMRIC funding to address remedial minor capital works focused on infection prevention
  Status: Complete
  (Responsible person: Assistant Hospital Manager/Maintenance Manager/ ADON for IPC)

Timescale: